MassHealth
Commonwealth of Massachusetts
Division of Medical Assistance
www.mass.gov/dma

Application
for Seniors and People Needing Long-Term-Care Services

Instructions

Please read these instructions before you fill out the MassHealth Application.

Dear Applicant:

You must fill out the enclosed MassHealth Application **(red form)** to apply for MassHealth if you live in Massachusetts and:

- are aged 65 and older and living at home;
- are any age and need long-term-care services in a medical institution; or
- are eligible under certain programs to get long-term-care services to live at home.

You will also need to fill out the Long-Term-Care Supplement **(blue form)** if you are:

- in an institution, like a nursing home, chronic hospital, or other medical institution; or
- in an acute hospital waiting for placement in a long-term-care facility.

If you are aged 60 and older and need long-term-care services to live at home, you may also need to fill out the Long-Term-Care Supplement. We will let you know.

After your application is filled out and reviewed, **you will be given the most complete coverage that you qualify for.**

There is a different application for you if you are:

- any age and both disabled and working 40 or more hours a month;
- under age 65 and not in a medical institution, and you do not need long-term-care services; or
- aged 65 or older and a parent or caretaker relative of children under age 19.

To get this other application, called a Medical Benefit Request (MBR), call the MassHealth Customer Service Center at **1-800-841-2900** (TTY: 1-800-497-4648 for people with partial or total hearing loss).

This application package contains:

- a MassHealth Application **(red form)**
- a Long-Term-Care Supplement **(blue form)** (including IRS Form 4506)
- a Personal-Care Attendant Supplement **(gold form)**
- a Primary Language Identification Form
- information about voter registration (You do not need to register to vote to get MassHealth.)
- the "MassHealth and You" guide, which explains who is eligible for MassHealth, what the income and asset rules are, what medical services you can get under MassHealth, and what your rights and responsibilities are
- a MassHealth Eligibility Representative Designation Form (If you want someone to act on your behalf, you can use this form to tell us who this person is.)

When you fill out the MassHealth Application, remember to:

- **Read carefully the "MassHealth and You" guide before you fill out the application. Keep the guide. It may answer questions you have later.**
- Answer all questions and fill out all sections on the application and on any supplements. If you need more space, use a separate sheet of paper, and attach it to the application.
- **Send proof of all current income before deductions,** like copies of pension check stubs. (You do not have to send proof of social security income.)
- **Send proof of all assets,** like bank accounts and life insurance policies.
- If you or your spouse who is applying is not a U.S. citizen, send a copy of both sides of all immigration cards (or other documents that show immigration status).
- Send a copy of both sides of **all** health-insurance cards for those who are applying, and copies of current premium bills. (You do not have to send copies of your Medicare cards.)
- **Sign and date all the forms after you finish filling them out.** If you are married, your spouse must also sign.
- Submit a filled-out MassHealth Eligibility Representative Designation Form, if you are filling out this application as an eligibility representative or if you want someone to act on your behalf.
- After you have filled out the MassHealth Application (MHA) and any needed supplements, **send** the filled-out MHA, any supplements, and any needed papers **to the one MassHealth Enrollment Center (MEC) listed below that is closest to where you live.**

Revere MEC
300 Ocean Avenue
Suite 4000
Revere, MA 02151

Taunton MEC
21 Spring Street
Suite 4
Taunton, MA 02780

Springfield MEC
333 Bridge Street
Springfield, MA 01103

Tewksbury MEC
367 East Street
Tewksbury, MA 01876

If you need more information about how to apply, or if you need another copy of the Long-Term-Care Supplement or Personal-Care Attendant Supplement for your spouse who is also applying, call the MassHealth Customer Service Center at **1-800-841-2900** (TTY: 1-800-497-4648 for people with partial or total hearing loss).

If you want us to share information about your MassHealth eligibility (including copies of notices we send you) with someone other than your Eligibility Representative, if you have one, please call MassHealth. MassHealth can give you a MassHealth Permission to Share Information form.

If you have any questions about any form or the information you need to send, please call a MassHealth Enrollment Center at **1-888-665-9993** (TTY: 1-888-665-9997 for people with partial or total hearing loss).

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For office use only
Application I.D.: _____
Date received:

You do not have to be a U.S. citizen to get MassHealth.

Please print clearly. Answer all questions and fill out all sections. If you need more space to finish any section on this form, please use a separate sheet of paper, and attach it to the application.

Are you applying for or getting long-term-care services? ☐ yes ☐ no

Applicant Information

Last name	First name	MI	Telephone number ( )	Marital status	Home
				☐ single ☐ married ☐ separated ☐ widowed ☐ divorced	☐ own ☐ rent
Home address			City	State	Zip
Mailing address *(if different from home address)*			City	State	Zip
Social security number*	Date of birth / /	Race *(optional)*	Sex ☐ M ☐ F / Primary language	Are you disabled? ☐ yes ☐ no blind? ☐ yes ☐ no	U.S. citizen? ☐ yes ☐ no
Name and address of hospital, nursing facility, or other institution *(if applicable)*					Date of admission / /

Spouse Information

Last name	First name	MI	Telephone number ( )	Home address *(if different from above address)*

Social security number*	Date of birth / /	Race *(optional)*	Sex	Applying?	If ***applying***, are you: U.S. citizen?	disabled?	blind?	applying for or getting long-term-care services?
			☐ M ☐ F	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no

Name and address of hospital, nursing facility, or other institution *(if applicable)*	Date of admission / /

Previous Medical Bills

Do you or your spouse have bills for medical services you got in the 3 months before the month we got your application? ☐ yes ☐ no
*If **no**,* go to the next section *(Previous Assistance).*
*If **yes**,* fill out this section.

Do you or your spouse want to apply for MassHealth for that time period? ☐ yes ☐ no

*If **yes**,* what is the earliest date for which you need MassHealth? ____ / ____ / ____
(We will tell you what information you need to give us.) month day year

Previous Assistance

Have you or your spouse ever gotten Supplemental Security Income (SSI)? ☐ yes ☐ no
*If **no**,* go to the next section *(Personal-Care Attendant Services).*
*If **yes**,* fill out this section.

When did you or your spouse last get SSI? ____ / ____ / ____ month day year

Does anyone else pay for any part of your rent, mortgage, or other living expenses? ☐ yes ☐ no

*If **yes**,* please explain: _____

Do you: *(Please check (✓) one.)*
☐ live with spouse? ☐ live in a licensed rest home? ☐ live alone? ☐ other? (describe: _____)

* Not required if applying for MassHealth Limited.

Personal-Care Attendant Services (for people aged 65 and older who are not going into a long-term-care facility)

To get more information about personal-care attendant (PCA) services, and how filling out this PCA section could affect the way we decide if you can get MassHealth if you do need PCA services, read Part III of the "MassHealth and You" guide that is enclosed.

▶ Have you or your spouse had the services of a personal-care attendant **paid for by MassHealth** within the last 6 months?

You ☐ yes ☐ no
Your spouse ☐ yes ☐ no

*If **yes**, go to the next section (Income from Working).*
*If **no**, answer the following three questions in this section.*

▶ Do you or you spouse have a permanent or long-lasting disability?

You ☐ yes ☐ no
Your spouse ☐ yes ☐ no

*If **yes**, does your (or your spouse's) disability keep you (or your spouse) from being able to do your (or your spouse's) daily living activities, like bathing, eating, toileting, dressing, etc. unless someone physically helps you (or your spouse)?*

You ☐ yes ☐ no
Your spouse ☐ yes ☐ no

*If **yes**, do you (or your spouse) plan to contact a MassHealth personal-care attendant agency to ask for personal-care attendant services?*

You ☐ yes ☐ no
Your spouse ☐ yes ☐ no

(Note: You must contact the PCA agency within 90 days of the date that the Division decides you are eligible for MassHealth or you will not be able to benefit from the special PCA rules.)

(MassHealth will not pay certain members of your family to be your personal-care attendant.)

*Each spouse who answered **yes** to the last three questions above* must fill out his or her own Personal-Care Attendant Supplement (gold form). One copy is enclosed.

Income from Working

▶ Do you or your spouse have income from working? ☐ yes ☐ no

*If **no,** go to the next section (Nonworking Income).*
*If **yes,** fill out this section.*

✉ **Send proof** of this income (for example: copies of two current pay stubs or your federal tax return if self-employed).

	You			Your spouse		
▶ Are you employed?	☐ yes ☐ no	Monthly amount before deductions $	Hours per month	☐ yes ☐ no	Monthly amount before deductions $	Hours per month
Employer name and address:						
▶ Are you self-employed?	☐ yes ☐ no	Monthly amount before deductions $	Hours per month	☐ yes ☐ no	Monthly amount before deductions $	Hours per month

Nonworking Income

▶ Do you or your spouse have any other income, including rental income? ☐ yes ☐ no
*If **no**, go to page 4 (Health Insurance).*
*If **yes**, fill out this section, and the rest of this page (Rental Income).*

✉ **Send proof** of income before deductions (for example: check stub or award letter). (You do not have to send us proof of social security income.)

	You Monthly amount before deductions	Your spouse Monthly amount before deductions
Social Security/Railroad Retirement	$	$
Veterans' benefits (state or federal)	$	$
Retirement/Pension	$	$
Annuity	$	$
Dividend/Interest	$	$
Trust income	$	$
Other (identify:)	$	$

Rental Income

▶ *If you have **rental income** from any real estate,* including your home, fill out this section.

✉ **Send proof** of current rental income, like a written statement from each tenant or a copy of the lease, or a current federal tax return.

✉ **Send proof** of all of the following expenses, if applicable, for the last 12 months:

- mortgage
- taxes
- utilities (gas/electric)
- heat
- water/sewer
- insurance
- condo or co-op fee
- repairs and maintenance

▶ What type of real estate do you own?
☐ one-family ☐ two-family ☐ three-family ☐ other (describe: _____)

▶ How much monthly rental income do you get from each rental unit from the real estate indicated above? (List each rental unit and address separately.)

Address: _____ Unit #: _____ Amount: $ _____

Address: _____ Unit #: _____ Amount: $ _____

▶ Do you pay for heat and/or utilities for your tenant? ☐ yes ☐ no

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Applicant's name: _____ Applicant's SSN: _____

Health Insurance

▶ **Medicare**: Do you or your spouse have Medicare? ☐ yes ☐ no

▶ **Medicare supplemental insurance**: Do you or your spouse have supplemental health insurance (like Medex or AARP)? ☐ yes ☐ no

▶ **Other health insurance**: Do you, your spouse, or former spouse have other health insurance? ☐ yes ☐ no

*If you answered **no** to **all** of these questions,* go to the next section *(Accident Information).*
*If you answered **yes** to **any** of these questions,* fill out this section.

✉ **Send a copy** of both sides of all health-insurance cards, and copies of your current premium bills. (You do not have to send us copies of your Medicare cards.)

✉ **Send a copy** of the policy if you have long-term-care insurance.

	You	Your spouse
Medicare supplemental insurance (ex., Medex or AARP)		
Insurance company name		
Policy number		
Policy start date	/ /	/ /
Other health insurance (ex., HMO, dental, vision, long-term-care insurance)		
Insurance company name		
Group number		
Policy start date	/ /	/ /
Policyholder name		
Policyholder date of birth	/ /	/ /
Policyholder social security number		
Policy type	☐ individual ☐ couple *(2 adults)* ☐ family	☐ individual ☐ couple *(2 adults)* ☐ family

Accident Information

▶ Are you or your spouse applying because of an accident or injury that someone else might be responsible for? ☐ yes ☐ no

▶ Do you or your spouse have an injury, illness, or disability that was caused by someone else, or that could be covered by someone else's insurance or your or your spouse's own insurance other than health insurance (like homeowner's or auto insurance)? ☐ yes ☐ no

▶ Has a lawsuit, a worker's compensation claim, or an insurance claim been filed for you or your spouse as a result of an accident, illness, or injury? ☐ yes ☐ no

Instructions for telling us about your assets

You must fill out all blocks for each asset you or your spouse own. If you are applying for long-term care, you must *also* give us information about all assets you or your spouse owned in the last 36 months. If you have a spouse at home, also fill out the shaded blocks*. If you need more space, please use a separate sheet of paper, and attach it to this application.

Bank Accounts

- Do you or your spouse have any bank accounts or certificates of deposit, including checking, savings, personal needs account (PNA), credit union, NOW, and money-market accounts? ☐ yes ☐ no
- Do you or your spouse have any retirement accounts, including individual retirement accounts (IRAs), Keogh accounts, or pension funds? ☐ yes ☐ no
- Have you or your spouse or a joint owner closed any accounts in the last 36 months, including any accounts you had owned jointly with anyone else? ☐ yes ☐ no

If you answered ***no*** *to* ***all*** *of these questions,* go to the next section *(Life Insurance).*

If you answered ***yes*** *to* ***any*** *of these questions,* fill out this section.

✉ **Send a copy** of your passbooks updated within the last 45 days and/or a copy of your current account statements.

Name on account	Name of bank/institution	Account number	Account type
Current balance $	☐ account open ☐ account closed	Date account closed / /	Balance on admission date* $
Name on account	Name of bank/institution	Account number	Account type
Current balance $	☐ account open ☐ account closed	Date account closed / /	Balance on admission date* $
Name on account	Name of bank/institution	Account number	Account type
Current balance $	☐ account open ☐ account closed	Date account closed / /	Balance on admission date* $
Name on account	Name of bank/institution	Account number	Account type
Current balance $	☐ account open ☐ account closed	Date account closed / /	Balance on admission date* $
Name on account	Name of bank/institution	Account number	Account type
Current balance $	☐ account open ☐ account closed	Date account closed / /	Balance on admission date* $
Name on account	Name of bank/institution	Account number	Account type
Current balance $	☐ account open ☐ account closed	Date account closed / /	Balance on admission date* $

*Enter the account balance you had on the date of admission to medical institution.

Life Insurance

▶ Do you or your spouse have any life insurance? ☐ yes ☐ no

*If **no**,* go to the next section *(Trusts).*

*If **yes**,* fill out this section.

✉ **Send a copy** of the first page of all life insurance policies. If total face value of all policies exceeds $1,500 per person, also send a letter from the insurance company showing the current cash-surrender value (for all policies except term policies).

Name of insured person	Insurance company	Policy number	Face value
			$
			$
			$

Trusts

▶ Are you or your spouse the grantor, trustee, or beneficiary of any trust(s)? ☐ yes ☐ no

▶ Have you, your spouse, or someone else on your behalf contributed income or assets owned by you or your spouse to a trust? ☐ yes ☐ no

▶ Are you or your spouse a beneficiary of a trust established by someone else, including a court, administrative body, or any other person? ☐ yes ☐ no

*If you answered **no** to **all** of these questions,* go to the next section *(Prepaid Burial Plans/Trusts).*

*If you answered **yes** to **any** of these questions,* fill out this section.

✉ **Send a copy** of the trust document(s) showing financial activity and the schedule of beneficiaries.

Name of trust	Irrevocable?	Trustee(s)	Grantor(s)	Beneficiaries	Current trust principal	Trust principal on admission date*
	☐ yes ☐ no				$	$
	☐ yes ☐ no				$	$
	☐ yes ☐ no				$	$
	☐ yes ☐ no				$	$

Prepaid Burial Plans/Trusts

▶ Do you or your spouse have any prepaid burial contracts or trusts, life insurance set up for funeral and burial expenses, or bank accounts set aside for funeral and burial expenses? ☐ yes ☐ no

*If **no**,* go to the next section *(Stocks/Bonds/Other).*

*If **yes**,* fill out this section.

✉ **Send a copy** of the trust contract, trust instrument, insurance policy, or burial-only account.

	You	Your spouse
Burial contract	☐ yes (amount: $) ☐ no	☐ yes (amount: $) ☐ no
Burial trust	☐ yes (amount: $) ☐ no	☐ yes (amount: $) ☐ no
Life insurance for burial	☐ yes (total face value: $) ☐ no	☐ yes (total face value: $) ☐ no
Burial-only account	☐ yes (amount: $) ☐ no	☐ yes (amount: $) ☐ no

*Enter the trust principal you had on the date of admission to medical institution.

Stocks/Bonds/Other

▶ Have you, your spouse, or someone acting on your behalf given a deposit to any health-care or residential facility, like an assisted-living facility? ☐ yes ☐ no

*If **yes**, give us the name and address of the facility, the amount of the deposit, and the date it was given to the facility.*

✉ **Send a copy** of the documents.

Name of facility	Address of facility	Amount	Date
		$	/ /

▶ Do you or your spouse own any stocks, bonds, savings bonds, mutual funds, securities, assets held in safe-deposit boxes, or cash not in the bank? ☐ yes ☐ no

*If **no**,* go to the next section *(Vehicles/Mobile Homes).*

*If **yes**,* fill out this section.

✉ **Send a copy** of the documents.

	You			Your spouse		
	Company	Current value	Value on admission date*	Company	Current value	Value on admission date*
Stocks		$	$		$	$
Bonds		$	$		$	$
Savings bonds		$	$		$	$
Mutual funds		$	$		$	$
Securities		$	$		$	$
Other		$	$		$	$

Vehicles/Mobile Homes

▶ Do you or your spouse own any vehicles, including cars, vans, trucks, recreational vehicles, mobile homes, and boats? ☐ yes ☐ no

*If **no**,* go to the next section *(Annuities).*

*If **yes**,* fill out this section.

✉ **Send a copy** of the registration for each vehicle, and proof of the outstanding loan balance. For mobile homes, **send a copy** of the bill of sale. If you have a spouse at home, **send proof** of the fair-market value of each vehicle as of the date of admission to the medical institution.

	You	Your spouse
Type of vehicle		
Year/make/model		
Fair-market value	$	$
Amount owed	$	$

*Enter the account balance you had on the date of admission to medical institution.

Annuities

▶ Do you or your spouse own an annuity? ☐ yes ☐ no

*If **no**,* go to the next section *(Real Estate).*

*If **yes**,* fill out this section.

✉ **Send a copy** of the contract.

	You	Your spouse
Name of owner		
Name of person getting income		
Date purchased	/ /	/ /
Amount (purchase price)	$	$

Real Estate

▶ Do you or your spouse own or have a legal interest in any real estate other than your primary residence, including a life estate? ☐ yes ☐ no

*If **no**,* go to the next section *(Citizenship).*

*If **yes**,* fill out this section.

✉ **Send a copy** of the deed(s) and current tax bill(s).

Address	Type of property

Citizenship

▶ *If you and your spouse* ***are*** *U.S. citizens,* you do not have to fill out the rest of this page. Go to page 10.
▶ *If you or your spouse* ***are not*** *U.S. citizens,* and you are applying, you must fill out the rest of this page.

1. Are you or your spouse a veteran of the United States Armed Forces with an honorable discharge or did you or your spouse serve under U.S. command during World War II or in Vietnam? ☐ yes ☐ no
   If ***yes,*** you may stop here and go to page 10.
   If ***no,*** go to the next question.

2. Are you or your spouse the widow or widower of a veteran described above? ☐ yes ☐ no
   If ***yes,*** you may stop here and go to page 10.
   If ***no,*** go to the next question.

3. Are you a victim of domestic abuse and no longer living with the abuser? ☐ yes ☐ no
   If ***yes,*** you may stop here and go to page 10.
   If ***no,*** you must fill out the rest of this page *(Immigration Status).*

Immigration Status

▶ List *all* statuses that have applied to you or your spouse since entering the U.S.

✉ **Send copies** of both sides of all immigration cards (or other documents that show immigration status).

Note: If you and your spouse are applying only for MassHealth Limited, you do not have to give us a social security number. We will not match your names with any other agency including the Department of Homeland Security (DHS). You do not have to list your names on this page or send proof of your immigration status. MassHealth Limited pays for emergency services only.

Use these codes to describe your status in the chart below.

4. Amerasian admitted pursuant to Section 584 of Public Law 100-202
5. Granted asylum
6. Conditional entrant
7. Cuban/Haitian entrant
8. Deportation withheld
9. Legal permanent resident
10. Native American with at least 50% American Indian blood born in Canada
11. Granted parole
12. Refugee
13. Person with a temporary visa/other
14. Person residing under color of law (PRUCOL)

Name	Status codes (List all that apply.) a	b	c	d	Date status awarded a	b	c	d	U.S. entry date
									/ /
									/ /

You, your spouse, and/or your eligibility representatives must read this page carefully, then sign and date it at the bottom.

I give permission for my current and former employers and health insurers to release to the Division any and all information they have about my health-insurance coverage and health-insurance coverage for my spouse. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to me or my spouse.

I give permission to the Division to get any records or data to prove any information given on this application and any supplements, or other information I give to the Division once I am a member. If I or my spouse is found eligible for MassHealth, I give permission to the Division to get any records about medical services provided through MassHealth.

I understand that in some cases, the Division may place a lien against any real estate that I have a legal interest in. If the Division puts a lien against my property and I sell it, I may need to use money I get from the sale of that property to repay the Division for medical services that I get.

I understand that after I die, the Division may be able to get money from my probate estate. I understand that the "MassHealth and You" guide has important additional information about the Division's recovery rules and exceptions to these rules.

I understand that if I or my spouse is in an accident, or we are injured in some other way, and get money from a third party because of that accident or injury, we will need to use that money to repay the Division for certain medical services provided, as explained in the "MassHealth and You" guide. I also understand that I must tell the Division in writing, within 10 days, if I or my spouse files any insurance claim or lawsuit because of an accident or injury to me or my spouse.

I understand that if I or my spouse is eligible for MassHealth, I must tell the Division of any changes in my or my spouse's income or employment, assets, health-insurance coverage, and health-insurance premiums, or of changes in any other information I gave on this application and any supplements within 10 days of learning of the change.

I also understand that by signing below, I give permission to the Division to go after and collect third-party payments for medical care and medical support from my spouse who is living at home and refuses to cooperate or whose whereabouts is unknown.

I certify that I have read or had read to me the information on this application and the information in the "MassHealth and You" guide, and that I understand my rights and responsibilities. I further certify under penalty of perjury that the information on this application is correct and complete to the best of my knowledge.

If you are acting on behalf of someone in filling out this application, the enclosed MassHealth Eligibility Representative Designation Form must also be filled out and sent back with this application. Your signature on this application as an eligibility representative certifies that the information on this application is correct and complete to the best of your knowledge.

If you think the Division's decision about whether you are eligible is wrong, you have the right to appeal. If you are denied benefits, you will get information on how to appeal.

X _____ _____

Signature of applicant or eligibility representative — Date

X _____ _____

Signature of applicant's spouse or spouse's eligibility representative — Date